

Clinical Decision Making – Test 1

Draft 1

• Clinical Decision Making

○ Introduction to Clinical Decision Making

- Objectives
 - Identify and describe major components of clinical decision making
- Reductionism
- Process
 - Hypothesis generation, hypothesis testing, evaluating hypothesis
 - Identify the problem
 - Pertinent H&P/interpretation of findings
 - Generate hypotheses/differential
 - Seek supporting evidence
 - Test hypotheses and refine differential
 - Synthesize clinical information and generate case presentation

○ Introduction to Professionalism

▪ Part 1

- Objectives
 - Understand the link between professionalism, ethics and competency
 - Define professionalism
 - How professionalism is sabotaged
 - Understand the role of communication
- Medical board goal – rehabilitate doctors when possible, prohibit those that have not been rehabbed
- AMA Principles of Medical Ethics

Provide competent, compassionate medical care	Be free to choose work environment
Uphold standards of professionalism	Responsibility to community
Respect the law	Responsibility to patient
Respect rights of patients, colleagues and others	Support medical care for all people
Maintain commitment to continuing education	
- Competence – knowledge, judgment, clinical skills, integrity, respect, compassion
- Professionalism
 - Altruism –
 - Accountability – to patients, society and the medical profession
 - Excellence - exceed ordinary expectations
 - Duty – being available when called, advocate of patient, helping in community
 - honor, integrity – high standards of behavior, truthfulness, honesty, fairness
 - Respect – for patients, physicians, colleagues
- Ways to *sabotage* professionalism – abuse of power, arrogance, greed, misrepresentation (lying, fraud), impairment (substance abuse), lack of conscientiousness, conflict of interest
- *Communication is key*
 - Barriers – ‘unimportant’ details omitted, embarrassment, patient doesn’t understand jargon, patient can’t remember
 - Ways to improve – listen, eye contact, non-verbal, explain, reassure, ask patient to repeat
- *Attitude is everything* – professionalism boils down to relationships

▪ Part 2

- Professionalism – fundamental knowledge and skills complemented by values that are expressed as behaviors and/or attitudes in contexts and settings that span the educational experiences
 - 3 Components of Professionalism – ethical and legal understanding, communication skills, clinical competence
 - 4 Value Pillars of Professionalism – excellence, humanism, accountability, altruism

▪ Part 3 – Learning Environment and Professionalism

○ Introduction to Patient Centered Care – Part 1

- Objectives

- Identify potential hazards of cognitive shortcuts
- Identify adverse effects of physician bias
- Describe characteristics that make medical culture unique
- Compare and contrast the biomedical and patient-centered models of medical care
- **Process of Diagnosis**
 - Identify the problem
 - Pertinent H&P with interpretation
 - Generate hypotheses/differential
 - Seek supporting evidence
 - Test hypotheses and refine differential
 - Synthesize clinical information and generate case presentation
- Threats to Decision Making Process
 - **Cognitive Shortcuts**
 - Types
 - **Availability** – first thought is most likely
 - **Anchoring** – sticking with initial impression
 - **Framing** – making different decisions depending on how info is presented
 - **Premature closure** – all alternatives not pursued
 - Perception and past experiences play a big role
 - Ability to recognize patterns
 - Risks – remember there are many manifestations of the some diseases and that many diseases have the same manifestations
 - Remember to **be aware** of tendency to make cognitive shortcuts
 - **Bias** – a preference or inclination that inhibits impartial judgment
 - Subtle attitudes/behaviors can exert “self-fulfilling” prophecies
 - Need to remember to use experience to inform decisions, not to limit observations and analysis
 - **Health Literacy** – ability to understand basic health information
 - We have it, some patients might not
 - Remember to **identify the adverse effects of bias**
- Culture
 - Is the framework that shapes and directs how we behave and manner in which we interpret behaviors of others
 - Influences how illness is experienced and expressed
 - Components – ritual, belief, etiquette, taboo, openness, emotional expression
 - Traditional Medical Culture
 - Medical explanations = reality
 - **Evidence Based Medicine** forms of treatment = reality
 - Undervaluing of ambiguity and unscientific explanations
 - Problems with this
 - Does not allow for patient’s opinion, diseases not so simple anymore (long-term conditions), etc
 - Uses **biomedical model of care** – uses the word ‘it’ a lot. “where does **it** hurt”
 - Biased by evidence based medicine and the medical culture
- Patient Perspective
 - **Exploratory model of care** – uses the word “you” more often. “what are **you** concerned about”
 - Seek to get the **meaning of the illness** from the patient
 - Get the **social context review of systems** - impact on the patient, impact on others, support systems, resources, etc.
- What to do?
 - Examine own values, beliefs and traditions
 - Explore ways in which health, illness etc. are understood by different people

- Identify your own biases
- Challenge your assumptions
- Don't impose your idealized treatment goals, get the patient to take ownership of them

○ **Introduction to Patient Centered Care – Part 2**

- Objectives (know these)
 - Distinguish between race, ethnicity and geographic ancestry
 - Define culture and its various dimensions in medicine
 - Identify how culture relates to health and illness
 - Discuss the difference between disease and illness
 - Discuss the link between communication and health care
 - Discuss two models used to promote cultural understanding in the practice of medicine
 - Explain the importance of physician-patient negotiation
- **Culture** – framework that shapes and directs how we behave and the manner in which we interpret behaviors of others
 - Influences how illness is experienced and expressed
- **Race** – defined externally, sociopolitical construct, somewhat arbitrary
 - This isn't logical
- **Ethnicity** – self-defined, subjective, an individual's identity with a group (sharing culture, nationality, etc)
- **Geographic Ancestry** – objective, refers to genetic relationships between individuals and amount populations
 - **More accurate** in determining biologic risk factors than race
- **Stereotype** – *ending point*, no attempt is made to see if individual fits the mold, just assumed to
- **Generalization** – *starting point*, more information is used to see if individual fits mold
- **Cultural Competence** – *active* application of the awareness that different cultures have different values?
 - Tells other people about it
 - Doesn't come naturally, does not require extensive knowledge of different cultures
 - Enhances one's ability to adapt care to meet the needs of individual patients, understand patient's values, beliefs, expectations
 - Models that promote cultural competence
 - **Learn Model**
 - **L** – **listen** with sympathy and understanding to the patient's perception of problem
 - **E** – **explain** your perception of the problem
 - **A** – **acknowledge** and discuss the differences and similarities
 - **R** – **recommend** treatment/solutions
 - **N** – **negotiate** an agreement
 - **Kleinman's Questions**
 - What do you call the problem
 - What do you think has caused the problem
 - Why do you think it started when it did
 - What do you think your sickness does? How does it work?
 - What kind of treatment do you think you should receive?
 - What are the most important results you hope to receive from this treatment?
 - What are the chief problems the sickness has caused?
 - What do you fear most about the sickness?
 - **RESPECT Model**
 - **Rapport** – connect on a social level
 - **Empathy** – acknowledge and respond to patient's feelings
 - **Support** – provide support, involve family members
 - **Partnership** – stress that this is a collaboration, be flexible on the control issue
 - **Explanations** – make sure the patient understands

- **Cultural Competence** –
- **Trust** – make sure to establish trust
- **Disease** – theoretical construct by which we explain an individual's problems
 - Defined in terms of structure and/or function of bodily organs and systems
- **Illness** – an individual's personal experience of ill health
- **Spirituality** - *individual's* sense of the transcendent or that there is something bigger than self
- **Religion** – adherence to a structured practice of faith created by humans
 - **Religiosity** – amount of expression of religion

○ **Introduction to Interviewing and Communication Skills**

- **Objectives**
 - Recognize commonly used interviewing techniques when presented with patient-physician dialogue
 - Describe the elements of a complete medical history
 - Elicit a chief complaint, history of present illness, comprehensive health history, and past medical history from a standardized patient
- **Elements of the Interview**
 - Appropriately opening the interview and setting the patient at ease
 - Establishing the reason for the interview
 - Using a logical sequencing of questions (move from general to specific)
 - Appropriately closing the interview
 - Summarization, asking patient if they have any questions, telling patient what will happen next
 - Communicating with patients and their families conveying respect, interest and empathy
- **Interviewing Techniques**
 - **Non-verbal communication**
 - **Open-ended questions** – ex “so what brings you in today”
 - **Closed questions** – range of answers is restricted by the form of the question
 - **Directed questions** – trying to steer the patient in a certain direction. Useful with rambling patients
 - Ex – “so tell me about these headaches”
 - **Facilitating** – non-verbal or verbal way to encourage patient to say more about a subject
 - Ex. “you did?” “uh-huh”
 - **Reassuring** – put the patient at ease, but don't create false hope
 - **Confronting** – Describing the perception you get from the patient's verbal and non-verbal communication
 - **Validating** – communicates acceptance of and respect for the patient's emotional response or experience
 - **Silence**
 - **Echoing** – repetition of the patient's words to encourage more details
 - **Highlighting Transitions**
 - **Summarization**
- **Other Facts**
 - 70% of diagnoses are made on the basis of patient **interviews** alone
 - 70-80% of all relevant data are derived from the medical **interview**
 - 90% of diagnoses are made on the basis of **history and physical exam**
- **Complete Medical History**
 - **7 attributes of a symptom** – location, quality, severity, timing, setting in which it occurs, remitting or exacerbating factors, associated symptoms

○ **Sources of Data**

- **Objectives**
 - Describe the relative importance of history as a data source
 - Describe history-taking skills
 - Identify cues to patient needs
 - Describe threats to the validity of history data

- Identify threats to the validity of physical exam data
- Identify the vital signs and their purpose
- Describe principles for selection of laboratory tests in patient care
- Discuss the influence of disease prevalence and test sensitivity and specificity on interpretation of tests
- Patient History
 - Quality of physician-patient relationship influences quality of data exchanged
 - Generates data more often than physical exam and labs combined
 - Major way in which information is transmitted *to* patient
 - Threats to Validity
 - All histories are imperfect
 - Believing that the patient is a poor historian (really physician is the poor history taker)
 - Skills, time, bias, lack of rapport/trust, difficult circumstances
 - Skill
 - Be kind
 - Listen actively
 - Listen to what it is said and *how* it is said
 - Informed by interpersonal skills, knowledge of medicine
 - Focus patient upon a particular topic
 - Cues – indicate additional worries or symptoms the patient hasn't told you about
 - Ex. Stories about someone else's illness
 - Offering hypotheses
 - Speech dysfluencies (hesitations, pauses)
 - Time – time is relative
 - Rapport/Trust
 - Some symptom data are not elicited at all by doctor-centered approaches
 - Allow the patient to lead the conversation and discuss the symptoms or personal issues they prefer
 - Know what the patient expects from the interview and use that knowledge to elicit an accurate history
 - Share control of the interview with the patient
 - Patient is primary
- Physical Exam
 - Threats to Validity
 - Lack of thoroughness
 - Inadequate time
 - Skill
 - Inadequate rapport/trust
 - Each examiner is different
 - Look at the patient in their entirety
 - Exam begins as soon as you lay eyes on the patient
 - Vital Signs – temp, pulse, respiratory rate, blood pressure, oxygen saturation
 - Means of rapidly quantifying the magnitude of an illness and how well the body is coping with the resultant physiologic stress
 - Marker for chronic disease states
 - Can identify the existence of an acute medical problem
 - If it isn't written down it didn't happen
 - Discuss rationale for exam
 - Therapeutic touch
- Tests
 - No test is perfect
 - Why test?

- Screen for subclinical disease in asymptomatic patients
- To identify or clarify diagnoses in symptomatic patients
- To monitor status of known disease
- How to determine how much info/evidence you need from tests
 - History and physical
 - Acceptance of uncertainty
 - Prevalence of disease in the population
- Do you need the information to care for the patient?
- Will the results of the test affect the plan of care?
- Is there a better way to get the information that you need?
- Threats to Validity
 - Unexpected results may be errors
 - No test is perfect
 - Prevalence matters
 - Uncertainty (normal is a range based on 95% confidence interval of bell curve)
- Search for Literature
 - Obtain hard copies of outside studies
 - Document everything
- **Focused History**
 - **Complete History** – for new patient visits or comprehensive medical care
 - **Focused History** – appropriate for focused problems or emergency medical care
 - **Review of Systems** – systemic questioning about organ systems
 - Go from head to toe

General/constitutional	Genitourinary
Skin/breast	Musculoskeletal
Eyes/ears/nose/mouth/throat	Neurologic/psychiatric
Cardiovascular	Allergic/immunologic/lymphatic/endocrine
Respiratory	
Gastrointestinal	
- **Interviewing and Communication Skills – Special Topics I**
 - Objectives
 - Discuss the legal and policy requirements for providing language access services
 - Describe the disadvantages and advantages of various strategies for providing interpretation services
 - Recognize signs of professional and unprofessional interpretation
 - Describe techniques to effectively guide an interpreter when conducting an interview with a limited English proficient patient
 - Background
 - **Limited-English Proficient (LEP)** – individuals who do not speak English as their primary language AND who have a limited ability to read, write, speak or understand English
 - **Interpretation** – oral
 - **Translation** – written
 - Bad things happen when there is a language barrier in medical care
 - Legal Issues
 - **Title VI** – Prevents those receiving Federal financing from discriminating against populations
 - Ensures meaningful access of critical services to LEP persons without imposing undue burden
 - Even if only one part of an organization receives federal funds then the whole organization must comply
 - Number of LEP, Frequency of LEP and importance of service to LEP help determine how much one should comply
 - **CLAS** mandates
 - Language assistance services (LAS) must be provided at no cost to patient
 - People must be informed of their rights to LAS
 - Must assure competence of LAS

- Signs showing LAS must be visible
 - There are accrediting organizations that monitor this – JCAHO
 - Section 504 of Rehabilitation Act – covers hearing impairments
 - Americans with Disabilities Act – covers those with phys or mental impairment
- Interpretation Strategies
 - Bilingual staff, staff interpreters, contracted interpreters, telephone interpreters (no visual cues), community volunteers (maybe not at same standard), family member (many issues, but never use a minor)
- Triadic Interview Techniques
 - Put interpreter behind patient
 - Guide interpreter in their role
 - Make eye contact with the patient and speak directly to them
 - Use 1st person
 - Short sentences and one question at a time
 - Correct interpreter when needed
 - Avoid side conversations with interpreter
- **Interviewing and Communication Skills – Special Topics II**
 - Objectives
 - Describe strategies/techniques for addressing difficult topics
 - Describe strategies/techniques used when interviewing adolescents or elderly
 - Demonstrate those techniques in an interview with a standardized patient
 - Interviewing Challenges
 - Remember to identify your bias
 - Understand the power of your unspoken response
 - Address societal taboos
 - Diagnosis is to be used to aid recovery, not to label a person
 - **Substance Use**
 - Set the stage – **“these are some questions I ask all my patients”**
 - Ask about family history
 - Get clues from appearance, weight, job history
 - Know age-related risk, gender
 - Why intervention is helpful – pregnant patients, get patients to contemplate use, provide support or encouragement
 - Women are less likely than men to seek treatment for substance abuse
 - Stats – there are a lot of stats on substance abuse
 - Look out for about 20% of teens
 - 23% of OH adults smoke, 5.5% of OH adults are heavy drinkers, 4.4 million chronic drug users in US (3.6 crack users)
 - In Elderly
 - Substance abuse generally declines with age, but absolute number grows as population ages
 - 5-10% have alcohol problem
 - non-specific signs can often be misdiagnosed as depression or dementia
 - misuse or abuse of prescription meds is an issue
 - Tobacco
 - Stages of change – pre-contemplation, contemplation, preparation, action, maintenance
 - Sample Questions
 - Have you considered quitting? Are you planning to quit? Have you tried quitting? How are you avoiding smoking? Why do you think you are successful? How could you use what you’ve learned to quit again?
 - Alcohol/Drug Use

- **CAGE Questions**
 - Have you ever felt you should **cut down** on your drinking or drug use?
 - Have people **annoyed** you by criticizing your drinking?
 - Have you ever felt bad or **guilty** about your drinking?
 - Have you ever had a drink first thing in the morning (**eye opener**) to steady your nerves or to get rid of a hangover?
- **Drug Abuse Screening Test**
 - Have you used drugs other than those required for medical reasons?
 - Have you abused prescription drugs?
 - Do you abuse more than one drug at a time?
 - Can you get through the week without using drugs?
 - Are you always able to stop using drugs when you want to?
 - Have you had blackouts or flashbacks as a result of drug use?
 - Has drug abuse created problems between you and loved ones?
 - Have you lost friends because of your use of drugs?
 - Have you been in trouble at work because of your use of drugs?
 - Have you gotten into fights when under the influence?
 - Have you engaged in illegal activities in order to obtain drugs?
 - Have you ever experienced withdrawal symptoms when you stopped taking drugs?
 - Have you had medical problems as a result of your drug use?
 - Have you gone to anyone for help for a drug problem?
- **Sexual History**
 - Identify risky behavior, dysfunction, systemic illness, coercion
 - Adolescents at high risk for Chlamydia, gonorrhea, HPV, herpes, PID
 - Cervix has increased susceptibility to STIs and HIV
 - Make sure to ask about same-sex sexual history
 - Identify your bias and set it aside in order to help the patient
 - **Sexual intercourse** – any sort of penetrative sexual behaviors
 - **Gender Identity** – inner knowledge of being male or female
 - **Gender Role** – outward expression of an individual's gender identity
 - Influenced by cultural expectations
 - **Sample Questions**
 - Are you currently sexually active? Have you ever been?
 - Are your partners men, women, both?
 - How many partners have you had in the past month? Six months? Lifetime?
 - How satisfied with your (and your partner's) sexual functioning are you?
 - Has there been any change in your (or partner's) sexual desire or the frequency of sexual activity?
 - Do you have or have you ever had any risk factors for HIV?
 - Have you ever had any STIs?
 - Have you ever been tested for HIV? Would you like to be?
 - What do you do to protect yourself from contracting HIV?
 - What method of contraception do you use?
 - Are you trying to become pregnant or father a child?
 - Do you participate in oral/anal sex?
 - Do you or your partners use any particular devices or substances to enhance your sexual pleasure?
 - Do you ever have pain during intercourse?
 - Women – do you have any difficulty achieving orgasm?
 - Men – do you have difficulty obtaining and maintaining an erection? Difficulty with ejaculation?
 - Do you have any questions or concerns about your sexual functioning?
 - Is there anything about your sexual activity that you would like to change?
 - **The 5 Ps** - Partners, prevention of pregnancy, protection from STDs, practices, past STDs
- **Geriatric Interview**
 - Not just a large child
 - Presence of caregiver boon or bane?
 - Fully clothed
 - Speak slowly and clearly

- Ensure adequate time for response
- May fatigue easily
- Recall may be poor, do a mini-mental status exam
- **Make sure to cover** – mood, cognition, functioning (self care and instrumental daily living)
 - **Basic activities of Daily Living (ADLs)**
 - Bathing, dressing, eating (nutrition), toileting, mobility, continence
 - **Instrumental Activities of Daily Living (IADLs)**
 - Cooking, shopping, light housework, telephone, medications, managing money, transportation
- Get med list
- Ask about change in life circumstances
- Sexual Function
 - Sexual beings whether or not they are sexually active
 - Desire for closeness and pleasure
 - Chronic diseases such as hypertension, heart disease, osteoporosis, arthritis, incontinence, diabetes and emphysema affect sexual function
 - Amount of sexual activity generally decreases, but amount of sexual interest and ability remains fairly constant
 - There is more to sexuality than just vaginal intercourse
- **Adolescent Interview**
 - Trust, respect, non-judgmental, accessible, confidential
 - Ask questions about activities of the peer group, then ask specific behavioral questions
 - Give explanations for the reason for a question
 - Not just a small adult
 - Sexual Interview
 - Ask gender neutral sexual questions (so that they reveal if the action is with males or females)
 - Age of partner
 - Sexual violence or coercion? (males report psychological aggression)
 - Can deny consequences of sexual behavior
 - Good question to ask
 - Ask what the patient or their *friends* think about their behavior
- **Interviewing and Communication Skills – Special Topics III**
 - **Difficult Patient**
 - Physically, verbally abusive, hostile, dictating, uncooperative, drug-seekers, malingerers, unkempt, malodorous, loud
 - Categories
 - Those who cannot cooperate
 - Those who willfully do not cooperate
 - Those who actively interfere with treatment attempts
 - Manipulative patients
 - How providers respond – anger, frustration, disgust, generalizations, withdrawal, avoidance
 - How to manage a difficult patient

Ensure a safe atmosphere	DO NOT get emotionally involved
Rule out medical emergency	Speak calmly and rationally
Address underlying issues	Offer alternatives
Educate patient about alternatives	Maintain control of the situation
Do not be manipulated	Don't let it ruin your day
Respect patient autonomy (be nonjudgmental)	Avoid negative emotions
Patience	
 - **Domestic Violence**
 - Stats
 - 25% of all women will experience domestic violence
 - 73% of all family violence victims are women

- American Indian/Alaskan native women and men have higher rates of DV
- Risk Factors For:
 - **Perpetrator** - young age, low self-esteem, low income, low academic achievement, aggressive/delinquent behavior as youth, alcohol/drug abuse, **witnessing violence as a child, experiencing violence as a child**, social isolation, unemployment
 - **Relationship DV** – marital conflict, male dominance, poor family functioning, emotional dependence, belief in strict gender roles, etc
 - **Experiencing DV** – history of physical abuse, prior injury from same partner, having a verbally abusive partner, economic stress, partner history of drug/alcohol use, history of sexual abuse, <24 years of age
- Costs – socioeconomic, medical (stress related illness increases), psychological
- Detection
 - **Direct assessment** – required part of office or ER visit if injured
 - More than 40% of murdered victims seen at ER with injury in previous 2 years
 - **Indirect assessment** – provide info/safe haven information
 - Ask the patient, even if denied then in the future they will look to doc as safe haven
 - Ask when patient is alone
 - When universal screening used, detection went up 18x
 - **How to ask** (no set way)
 - **Partner Violence Scale**
 - Have you been hit, kicked, punched, or otherwise hurt by someone within the past year?
 - Do you feel safe in your current relationship now?
 - Is there a partner from a previous relationship who is making you feel unsafe now?
 - “We know that violence at home is a problem for many people, is there anyone who is hurting you in some way?”
 - Don’t forget to ask male patients as well
 - Teens (often using indirect questioning is a good way to start)
 - Ask if they have a friend or know someone who was involved in DV
 - **Once Identified, ask about**
 - Presence of children, if violence is escalating, if there are any weapons in the house
- Intervention
 - In General – make resources available and discuss DV at every visit
 - Once Identified
 - Offer to call police or battered woman shelter
 - If refused, then this cannot be violated
 - Offer resources
 - Contact children services if children are present
 - Help patient develop “escape plan”
 - Most dangerous time is when a woman tries to leave
 - Must decide ahead of time where to go
 - Should prepare an essentials kit in advance
 - **Don’t encourage confrontation**
 - Don’t tell patient what to do
 - Don’t encourage couples counseling
 - Do assess level of danger and inform patient
 - Do schedule a follow up
 - **Do hospitalize if they need a safe place**
- **How to Interview Children**
 - Preschoolers
 - They don’t understand abstract concepts, they interpret language literally

- They don't put things into categories, so it is hard for them to respond to questions like "has anything 'like this' happened to you?"
- They have difficulty with pronouns
- They have difficulty with negatives
- They tend to give an answer even if they have no knowledge
- They do best with simple, short questions
- Tend to focus on only one aspect of a question
- They often don't understand that they don't understand
- They often don't understand sarcasm
- Children ages 7-10
 - Still may have difficulty with abstraction
 - Still may have trouble with complex questions
 - Easily confused with complex negatives
 - May not understand sarcasm, insincerity, irony
 - Not good at organizing events in a logical/chronological way
- Tips
 - Use simple phrases and words
 - Use proper names
 - Stay away from negatives
 - Only one idea at a time
 - Frame new topics
- **Screening for Depression**
 - Most patients present to primary care physicians with the symptoms but don't know they are depressed
 - Thus you **have to ask**
 - Screening
 - Indications – relative with depression, chronic diseases, obesity, chronic pain, financial strain, major life changes, pregnancy/postpartum, multiple vague symptoms, fatigue/sleep disturbance, substance abuse, elderly
 - **Two Simple Screening Questions** – about 90% sensitive and specific
 - Over the past two weeks, have you felt down, depressed or hopeless?
 - Over the past two weeks, have you felt little interest or pleasure in doing things?
 - **If Yes, then you must assess suicidality**
 - Asking does not implant thoughts
 - Initially ask if they feel "they would be better off dead"
 - Distinguish between suicidal ideation or a suicidal intent and plan
 - Determine means and if there are any command hallucinations
 - Determine alcohol or substance use
 - History of previous attempts
 - Ask in a destigmatizing, empathic way
 - Talk about the neurobiology/chemical imbalance
 - A positive screen test is **not** a positive diagnosis
 - Diagnosis
 - Ask closed-ended questions about 9 diagnostic criteria
 - DSM-IV Criteria
 - **SIG E CAPS** – must have 5 or more of the following (including depressed **Mood**, and diminished **Interest**)
 - **Mood** – depressed or irritable
 - **Sleep** – insomnia or hypersomnia
 - **Interest** – markedly diminished interest or pleasure from things (anhedonia)
 - **Guilt** – feelings of worthlessness or guilt

- Energy – fatigue or loss of energy
- Concentration – impaired concentration or indecisiveness
- Appetite – change in appetite or weight (often loss of, but doesn't have to be)
- Psychomotor – psychomotor agitation or retardation
- Suicide – recurring thoughts of death or suicide
- Clinically significant distress, change from previous functioning, not caused by direct effects of a substance, not caused by a medical condition, not better accounted for by bereavement, no manic or hypomanic episodes
- Assess suicide risk
- Ask about manic episodes, alcohol and drug use, recent losses or social stressors, new meds, previous depressive episodes, seasonal mood variation, family history, anxiety, compulsions
- Exclude other causes
- Document severity

• Ethics

○ Course Objectives

- Define and describe the significance of the major principles of bioethics, including respect for patient autonomy, beneficence, non-maleficence and justice
- Understand the ABC framework for analyzing ethical issues
- Compare important ethical opinions related to fundamental topics in medical ethics
- Formulate a rational approach to clinical ethical dilemmas
- Demonstrate the application of a framework for analysis and the principles of bioethics to clinical cases
- Integrate bioethical principles into the clinical practice of medicine

○ Professionalism – Panel Discussion

- Objectives
 - Describe the significance of attributes of professionalism in medicine
 - Identify the essential elements of medical professionalism
 - Discuss the application of professionalism to challenging clinical cases

○ The Patient Experience – Patient Panel and Small Group Discussions

- Objectives
 - Identify barriers to empathy and compassion in the physician-patient relationship
 - Discuss factors associated with patient vulnerability
 - Recommend strategies to increase the physicians empathy and compassion
- **Shark Attack Victim** – first time he felt vulnerable
- **Joyce Morris** – survivor of cancer for 50 years, still a hospice nurse
- **Phyllis Galo** – ovarian cancer
- **Crazy lady with kid** – child had huge gash on her arm that almost killed her due to blood loss, arm don't work right

○ Principles of Bioethics

- Objectives
 - Define and describe the significance of the major principles of bioethics, including respect for patient autonomy, beneficence, nonmaleficence and justice
 - Understand the ABC framework for ethical issues
 - Demonstrate the application of the principles of bioethics to clinical cases
 - Apply a framework for ethical issues to clinical cases
- **ABC Framework for Ethical Issues**
 - **Assessment** – Gather information, communicate with patient and other parties, assess objectives of interventions
 - **Gather information** about the case. Obtain information about the background, clinical information, and expected outcomes of various courses of action
 - **Communicate with the patient** regarding goals and values, and objectives of medical care in this clinical scenario. Discuss patient preferences

- If the patient is unable to communicate, obtain information regarding **advance directives**, previous conversations, or family opinions regarding patient preferences
- Communicate with family and friends regarding their opinions, goals and values, if patient consents
- Consider the involvement of **additional parties**, such as pastoral care, social work, or an ethics committee
- **Bioethical Principles and Values** – Identify and prioritize principles of bioethics and values relevant to the case
 - Identify bioethical principles applicable to the case. Principles may include:
 - Respect for **patient autonomy**
 - **Beneficence**
 - **Nonmaleficence**
 - **Justice**
 - Identify values applicable to the case. Values may include such concepts as **honesty, integrity, altruism, respect for life, justice, freedom and others**
- **Capacity** – assess capacity of the patient to participate in medical decision making
 - Assess the decisional capacity of the patient
 - If the patient does not possess decisional capacity, identify and advance directives or other communications of patient wishes
 - If necessary, identify a **surrogate decisionmaker** to speak on the patient's behalf. This is often defined by state law, and may include a hierarchy such as spouse, adult children, parents, etc. If no surrogate can be identified, a court appointed surrogate may be named
 - Can use **Mini-Mental Status Exam**
- **Decision** – make a timely decision
 - Identify possible courses of action
 - Weigh positive and negative ramifications of each possible course of action
 - Select the course of action that best adheres to ethical principles and values of the patient and physician
 - Make the decision in a **timely fashion** to allow for the best possible outcome
- **Evaluation** – assess the outcome and analyze the ramifications of the decision
 - Review the clinical outcome
 - Assess the opinions of the patient, family, and health care providers
 - Analyze in retrospect whether other options may have been preferable
- **Ethical Principles in Medicine**
 - The Big Four
 - **Respect for Autonomy**
 - Autonomy – being free from interference and control by others
 - Self-determinism, independence, freedom
 - Patients have the right to choose actions consistent with their own values and goals
 - Decisions should be free of coercion
 - **Nonmaleficence**
 - Nonmaleficence – do no harm
 - **Beneficence**
 - Beneficence – duty to do good
 - A positive duty requiring you to do something, not just avoid doing harm
 - Definition of good can vary between patients
 - **Distributive Justice**
 - Everyone should get what they deserve

- How is it decided who deserves what?
- Prima Facie Duties
 - Ethical duties or guidelines that should be followed unless they conflict with stronger obligations or unless there are compelling reasons to make an exception
 - **The burden of proof is on those who claim that an exception is warranted**
 - Should minimize the extent to which these rules are violated
- Where Ethical Principles Come From
- **Patient Autonomy – Perspectives in the Humanities**
 - Objectives
 - Describe the significance of patient autonomy in medical decision making
 - Identify factors that may contribute to patient autonomy
 - Construct a balanced approach to paternalism and patient autonomy
 - Didn't go to lecture
 - The Sea Inside
 - True story of Ramon Sampedro, a ship mechanic from Spain who was paralyzed after a diving accident at age 25. He campaigned for assisted suicide for 29 years
 - The Diving Bell and the Butterfly
 - True story of a French editor who had a massive stroke which resulted in him having Locked In Syndrome. He was paralyzed except for his left eyelid.
- **Physician-Patient Relationship, Vulnerable Patient & Sexuality**
 - Objectives
 - Describe significant elements impacting the physician-patient relationship
 - Identify barriers to a successful physician-relationship
 - Name specific patient populations that may be considered vulnerable
 - Discriminate between appropriate and inappropriate personal relationships between physicians and patients
 - Formulate strategies to improve vital aspects of the physician-patient relationship
 - **Physician-Patient Relationship**
 - Listening
 - The physician-patient relationship begins with listening
 - Physician must understand the patient's complaints, patient's underlying feelings, goals and expectations
 - Shared Decision Making
 - Involves respect for patient autonomy
 - Must get informed consent for treatment to be administered
 - Sometimes patient's don't understand due to inadequate discussion, fear, denial
 - Patients may not want to make decision
 - Relationship is built on **trust**
 - **Fiduciary relationship** – held or founded on trust or confidence
 - Trust that the patient's interest should take priority over the physician's or third party's interests
 - Physician may need to act to protect public health and this may involve a breach in patient confidentiality
 - **Medical Paternalism** – when the physician does what he or she believes is best for patient even if it overrides the patient's choices
 - **Vulnerable Patients**
 - Patients are vulnerable because of the unequal power of the relationship.
 - Patients can be more vulnerable because of a lack of dignity
 - Unfamiliar surroundings, dressing in night clothes in daytime, short hospital gown etc
 - Exceptionally Vulnerable – patients with mental disabilities, communication problems, minorities, prisoners, uninsured, children

- How to minimize a patient's vulnerability
 - Recognize it
 - Take steps to assure communication
 - Understand their beliefs, concerns, expectations
 - Respect patient and avoid personal judgments
- Informed Consent
 - Goes **beyond** whether consent was given and focuses on the **content** and **process** of consent
 - **Threshold Element** – competency of capacity to consent
 - **Information Elements** – disclosure of information & understanding of information
 - **Consent Elements** – voluntary consent & consent or authorization
- Decision-Making Capacity
 - **Capacity** – a **clinical** decision based on decision-making ability
 - **Competence** – a **legal** decision
 - A patient may have capacity or competence in one area, but not in another (ie not understanding legal terms)
 - A patient may not be about to weigh pros and cons of something, but will be able to tell you that a family member can make the appropriate decision
 - Clinical Standards for decision making capacity
 - The patient makes and communicates a choice
 - Appreciates the medical situation and prognosis, the nature of the recommended care, alternative courses of action, risks, benefits and consequences of each alternative
 - Decisions are consistent with the patient's goals and values
 - Decisions do not result from delusions
 - The patient uses reasoning to make a choice
- **Sexuality and the Profession**
 - "It is unethical for a physician to become sexually involved with a current patient even if the patient initiates or consents to the contact"
 - because the patient-physician relationship entails special obligations for the physician to serve the patient's interest because of the specialized knowledge that physicians possess and the imbalance of power caused by the medical relationship
 - "A sexual relationship with a former patient is unethical if the physician uses or exploits the trust, knowledge, emotions or influence derived from the previous relationship"
 - In psychiatry all current and former patients are off limits
 - Most common reasons for malpractice suits for mental health professionals
 - Long term psychological impact similar to rape or incest
 - Before becoming involved with a former patient, consider the possibility of undue influence and psychological impact upon the patient
- **Privacy and Confidentiality Plenary and Small Group Discussion**
 - Objectives
 - Identify historical and legal foundations of privacy and confidentiality in medicine
 - Describe the physicians's moral duty to maintain confidentiality
 - Explain circumstances in which it is ethically and legally appropriate to breach confidentiality
 - Discuss methods to protect patient confidentiality
 - Why protect confidentiality?
 - Ethical duty, legal duty, patient trust, protect patient's relationships, prevent discrimination
 - When to breach confidentiality?
 - When patients or other parties are endangered
 - Public reporting statutes (contagious diseases, abuse or domestic violence, criminal injuries)
 - Judicial proceedings

- Legal Acts to Protect Privacy and Confidentiality
 - JCAHO - administered by hospitals?
 - HIPAA - health insurance portability and accountability act
 - Privacy Rule - part of HIPAA that protects individuals' medical records
 - **Protected Health Information** is protected - any personally identifiable information (anything that can tie info to a specific person)
 - Information must be provided to patients regarding privacy rights
 - Employees must be trained in privacy procedures
 - Patient records must be secured
 - Authorizations to information given
 - **Free Use** - law, public health, national security
 - **Opportunity to Object** - family members, directory?
 - **Specific Authorization** - psychotherapy, marketing, fundraising, etc.)
 - General Provisions
 - Patient consent is required prior to disclosure of health info
 - Emergency exceptions are allowed
 - Written consent must be **obtained only once** by the provider
 - Implications for Research
 - Must have patient consent unless various stipulations are met
 - Implications for Minors
 - Parents generally have the authority to access minors' medical records
 - Exceptions dependent on state law, often includes mental health treatment, pregnancy, contraception, STDs
 - Exception - abuse or neglect
 - Public Health Implications
 - Protected health information may be disclosed without written consent when:
 - Public health surveillance, child abuse, neglect
 - Notification to persons at risk of a communicable disease
 - Law Enforcement Implications
 - Protected health information may be disclosed without written consent when:
 - Court order, subpoena
 - Limited info can be disclosed for purposes of identifying or locating a suspect
 - Exceptions to Confidentiality
 - Ex - criminal injuries, impaired drivers, partner notification by public health, warnings by physicians to people at risk, infectious diseases, child abuse, elder abuse, domestic violence
 - What diseases are reportable in the State of Ohio?
 - Diseases of major public health concern because of the severity of disease or potential for epidemic spread
 - Disease of public health concern needing timely response because of potential for epidemic spread
 - Diseases of significant public health concern
 - Filming of Patients - Consent Issues
 - Recording with consent - the JCAHO guideline
 - Recording without consent
 - Disseminating with consent
 - Disseminating without consent
- **Conflicts of Interest**
 - Objectives
 - Define conflict of interest
 - Identify clinical and research scenarios that may pose a real or perceived conflict of interest
 - Contrast appropriate and inappropriate referrals to other health professionals
 - Discuss strategies to avoid potential conflicts of interest in the research and clinical settings

- Working with a team
 - All members of the team (consultants, nurses etc) are committed to the patient's interest and all have equal moral status
 - Consultants should share findings and recommendations with the primary physician and the patient
 - Authority for patient care shouldn't be delegated to physicians in training
- Conflicts of Interest
 - A conflict of interest exists when a person entrusted with the interests of a client, dependent or the public violates that trust
 - Integrity of medical judgment may be compromised
 - Patients may lose trust that clinicians are acting on their behalf
 - Examples – gifts from drug companies, medical errors, impaired clinicians, clinical research (financial incentives), student training
 - Reducing Conflicts of Interest
 - Disclose conflicts of interest
 - Prohibit certain things (codes, legislation etc)
 - Reduce opportunities for conflicts of interest

○ **Ethical Issues in Genetics**

- Objectives
 - Identify ethical issues that influence genetic counseling
 - Name factors that should be considered prior to prenatal genetic testing for genetic traits, gender or disability
 - Integrate ethical issues into a rational approach to prenatal testing and counseling
- Prenatal Testing
 - Ethical questions about prenatal testing
 - Should all pregnancies be screened for genetic abnormalities?
 - Should parents have the right to take action based on genetic disorders?
 - Who defines health and disease?
 - Who defines normalcy?
 - What diseases or disabilities are considered incompatible with life, or unworthy of life?
 - Should carriers conceive
 - Should affected individuals have health insurance coverage?
 - Should insurers cover affected patients if prenatal testing diagnosed the condition
 - Should carriers disclose their status?
 - Should parents test for healthy offspring?
 - Can parents request non-disclosure of their individual genetic status?
 - Should children be conceived and selected for stem cell donation?
 - Should embryos be selected for preferred gender?
 - What is the threshold for aborting an abnormal embryo or fetus?
 - Pro Prenatal Testing
 - Autonomy of parents, right to information
 - Con - Prenatal Testing
 - Disease is not defined by genetics all the time
 - Right to life of unborn
 - Information can lead to anxiety or psychological disorders
 - Information may be incorrect
 - Statistics
 - **Sensitivity** - true positives
 - How likely the test detected people with the condition
 - $TP/(TP+FN)$
 - Means few missed cases – tests for life threatening diseases need high sensitivity
 - **Specificity** - true negatives

- How likely a negative test result is actually negative
 - $TN/(TN+FP)$
 - If the treatment is risky then high specificity is preferred
- **Likelihood Ratio** - likelihood that the test will be positive in patients with the disease compared to those without the disease
 - 10 or higher is significant, 2 or higher is 'useful'
 - Sensitivity/(1-specificity)
- Down Syndrome
- Prenatal Diagnosis
 - **Screening Tests** - estimate the risk of a condition by testing fluids for substances
 - **Triple Screen** - measures substances in blood
 - Ultrasound
 - Low sensitivity, high specificity - so many positive results are false alarms
 - **Diagnostic Tests** - tells whether or not the baby actually has Down syndrome
 - Ex. amniocentesis, chorionic villus sampling (CVS), precutaneous umbilical blood sampling
- Cystic Fibrosis
- Indicators for Genetic Testing
 - Family Medical History
 - Pregnancy History
 - Ethnicity based carrier screening
 - Asian - increased thalassemia, CF
 - Hispanic - nothing specific
 - African-American - very high sickle cell
 - Ashkenazi Jewish - Tay Sachs, CF etc
- Carrier Screening
 - Counseling should include
 - Purpose, voluntary nature
 - Meaning of positive and negative results
 - Documenting informed consent discussion is essential
 - It is **optional**
- Adult Genetic Testing
 - Objectives
 - Identify advances in genetic testing and associated ethical issues
 - Describe appropriate uses of genetic testing in clinical cases
 - Compare contrasting viewpoints on the widespread application of genetic testing
 - Discuss the significance of confidentiality for genetic testing, including release of information to relatives, health care providers and insurers
 - Recommend a rational approach to genetic testing and its application in clinical medicine
 - Ethical Issues
 - Do the children of a positive person have the right to know if they carry the abnormal gene
 - What are the risks of childbirth or avoiding childbirth?
 - What are the effects on future employment, relationships, and productivity?
 - Patient autonomy
 - Patient confidentiality
 - Significance attached to results
 - Value of human life
 - Impact of negative results on quality of life
 - Insurance discrimination
 - Problems with Genetic Testing
 - Most genes have variable penetrance and expressivity
 - Most conditions are polygenic
 - Genetic testing does not predict behavior, environment, education, diagnosis, or healthcare

- Confidentiality
- Duty to relatives
- BRCA - a tumor suppressor gene
- Disclosure to Insurers
 - Genetic Nondiscrimination Act - prohibits improper use of genetic information in health insurance and employment

○ **Genetic Testing – Patient Interview and Case Discussion**

- Objectives
 - Identify advances in genetic testing and associated ethical issues
 - Describe appropriate uses of genetic testing in clinical cases
 - Compare contrasting viewpoints on the widespread application of genetic testing
 - Discuss the significance of confidentiality for genetic testing, including release of information to relatives, health care providers, and insurers
 - Recommend a rational approach to genetic testing and its application in clinical medicine
- Sister of Medical Student
 - Said no to triple screen
 - Ultrasound found club feet etc. → probably trisomy 18 or 13
 - No amniocentesis chosen
 - Induced labor but baby had already died
 - ‘she was hoping for a miracle’
- Mrs. Resky
 - BRCA-1 gene - tested positive after sister diagnosed with ovarian cancer
 - Had preemptive mastectomy and ovary removal
 - Insurance doubled 2x afterwards

○ **The Future of Genetic Testing**

- Objectives
 - Identify advances in genetic testing and associated ethical issues
 - Describe appropriate uses of genetic testing in clinical cases
 - Compare contrasting viewpoints on the widespread application of genetic testing
- Gattaca
 - Designer babies genetically engineered to be the optimal recombination of their parents’ genetic material
 - Those not conceived in this way were termed in-valid and discriminated against
- Discuss the significance of confidentiality for genetic testing, including release of information to relatives, health care providers and insurers
- Recommend a rational approach to genetic testing and its application in clinical medicine

● **Small Group**

○ **Orientation to Small Group Case Discussions**

- [AccessMedicine](#): preclinical and clinical textbooks, drug info
- [MD Consult](#): clinical textbooks, practice guidelines
- [PIER](#): evidence-based clinically relevant information
- [ACP Medicine](#): systems-focused information

● **Cultural Competence Modules**

○ **Session 1 - Cultural Competence**

- Goal of cultural competence is to eliminate disparities in medicine
- Disparities
 - Ex - Minorities are more likely to refuse recommended services, adhere poorly, delay seeking care
- Make effort not to force someone to change their belief system to the medicocentric one where a pill will make you better
- Culture, family and religion may come into play

- **Paternalism** - treatment of patients is conducted in a fatherly, condescending way for patients own good
- **Autonomy** - Every human being of adult years and of sound mind has a right to determine what shall be done with his body
- **Proper Negotiation of Treatment**
 - **Three Elements**
 - 1. engaging patients with a participatory decision making style
 - 2. negotiate with the patient between effective medical, surgical, and alternative healing methods, and within their religious and cultural context
 - 3. discuss, don't tell
 - Outcomes are affected by cultural competence failures
 - It is better when physicians play a participatory decision making role
 - Participatory decision making should be encouraged with all patients
 - Don't rely on stereotypes, instead meet the needs of individual needs
- **Cognitive Shortcuts**
 - **Gestalts** - cognitive shortcuts
 - **stereotype** - an ending
 - **Generalization** - a beginning
 - **Prejudice** - a judgment, the outcome of a stereotype
 - **Bias** - an angle, our way of seeing the world
- The crux of cultural competence is understanding and recognizing your bias
- You can't let your bias get in the way of proper medical care. How do we do that? Proper negotiation of treatment
- What is Culture
 - Can include profession
 - Things passed through the generations not through genes
- Diversity
 - Diversity is not easy to recognize
 - Not every patient will represent the beliefs and values of a culture to the same degree
 - Acculturation - the process of modifying ones own culture when interacting as a minority within a dominant culture
- Information here MAY NOT NECESSARILY BE TRUE
- Steps to becoming culturally competent
 - 1. awareness - learning to think properly
 - 2. knowledge - learning specific cultural facts
 - 3. skills
- Summary of session 1
 - There are disparities in health outcomes that correlate with race and ethnicity
 - UTCOM is looking into correcting those through cultural competence education
 - Culturally competent practice is ethical and effective practice
 - Don't go overboard
- **Religion and Medicine Session 2**
 - culturally competent medicine must acknowledge religion
 - Religion and Culture
 - are indissoluble
 - have evolved together
 - they inform one another
 - Discussing religion with patients
 - 63% of patients did wish to be asked about their religious beliefs

- most appropriate in the event of a serious medical situation (thus in these situations it IS appropriate)
- not so appropriate in less severe situations (not appropriate in routine visit)
- spiritual concerns become increasingly important to patients as death grows nearer
- Diversity of Religion
 - each religion is divided and subdivided into many denominations
 - each of these may have a very, very different worldview
 - Could say that there are as many interpretations of religions as there are people
- Religions
 - **Hinduism**
 - **Henotheistic** - belief in many gods, but worshipping only one
 - Core Beliefs
 - Dharma - proper behavior, religious teaching, the soul, and transcendence
 - Karma - the cosmic law of human action and cosmic effect
 - Samsara - the wheel of reincarnation
 - Hinduism and Medicine
 - Avurveda - traditional hindu medicine
 - Dosha - elemental humors, the imbalance of which results in disease
 - Cure is specific to the individual, not the disease
 - **Judaism**
 - Core Beliefs
 - Monotheistic
 - The Jews are a "chosen people"
 - Therefore, they have special religious obligations
 - Judaism and Medicine
 - Jewish people are obligated to take care of their bodies (can be by making use of medicine, listening to advice of doctors)
 - Dietary Restrictions - no pork, no combination of meat and dairy
 - **Buddhism**
 - Practice mindfulness and meditation
 - Core Beliefs
 - Samsara, karma & Dharma
 - interdependence of existence
 - Change is inevitable and pervasive
 - Suffering is caused by desire
 - Buddhism and Medicine
 - Few strict restrictions on behavior
 - Health of the mind and body are interdependent
 - Illness results from disequilibrium of the four elements
 - past misdeeds MAY result in illness via karma
 - MAY be reluctant to take sedatives or painkillers
 - **Christianity**
 - Generally, christian bioethics is similar to that of Western medicien
 - Core Beliefs
 - Monotheistic
 - Jesus was the son of God
 - Ressurrection
 - Second Coming
 - Christianity and medicine
 - abortion, birth control, euthanasia
 - **Islam**

- Goal - Creation of a perfect, peaceful world by the observance of God's law
- Core Beliefs
 - Monotheistic
 - Muhammad is God's prophet
- Islam and Medicine
 - Islam requires that its adherents pay attention to their own health as well as to public health
 - Any substance that man can manufacture to alleviate illness is allowed and encouraged
 - Islam and Arabs
 - Arabic people are actually the smallest group of Muslims in the US
- Diversity
 - Hinduism - a western catch all term
 - Judaism - orthodox, conservative, reconstructionist, reform
 - Buddhism - mahayana, theravada, vajrayana
 - Christianity - 100 different denominations in the US
 - Islam - Shia and Sunni
- **Session 3 - Cultures and Their Health**
 - Ethnic groups are never defined by belief, they are defined by nationality, geography, language and history
 - Does teaching about cultures do more harm than good?
 - Are we learning stereotypes
 - Does this encourage social triaging?
 - Social Triage - the allocation of health care resources based on social or ethnic status
 - It is more important to negotiate treatment based on information you collect from the patient
 - Family - Nuclear vs Extended
 - Cultures
 - **African Americans**
 - 13% of US, 23.5% of Toledo
 - The worst health outcomes of all American ethnic groups
 - disparities remain even after correcting for socioeconomic factors
 - ex - mortality rates 30% greater for all types of cancer
 - MAY view the medical center as hostile
 - MAY be reluctant to trust physicians
 - **Latinos**
 - 13% of US
 - 6.2% of Toledo
 - From Central and South America
 - Geographical proximity to homeland may decrease desire for acculturation
 - Lower average age and higher birthrate
 - **Arabs**
 - .3% of population in US
 - Those who speak the Arabic language
 - Many arabs are not Muslim
 - Islam has influenced even Christian Arabs
 - Islam is NOT universally oppressive of women
 - Maintenance of modesty IS nearly universal
 - Men may avoid physical contact with the opposite sex for the sake of propriety (out of respect for women)
 - **Asian Americans**
 - 4% of US
 - Lower average age and higher birthrate
 - Smoking rate in men is highest of any ethnic group

- Liver and stomach cancer is higher than any other ethnic groups